South Central MIRECC

Reducing mental health disparities among rural veterans

Communiqué

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INSIDE THIS ISSUE

The next issue of the *South Central MIRECC Communiqué* will be published March 4, 2009. Deadline for submission of items to the March newsletter is February 23rd. Urgent items may be submitted for publication in the *Communiqué Newsflash* at any time. Email items to the Editor, Mary Sue Farmer, at Mary.Farmer2@va.gov

South Central MIRECC Internet site: www.va.gov/scmirecc

National MIRECC Internet site: www.mirecc.va.gov

NEW VISN 16 RURAL HEALTH CONSULTANT: DEANNA JACKSON MOORE, LMSW

Interviewed by Carrie Edlund, MS

Deanna Jackson-Moore, LMSW, VISN 16 Telehealth Programs Manager, recently accepted the position of VISN 16 Rural Consultant. She described her position and the VISN's plans to improve access to a full spectrum of health care for rural veterans in a recent interview.

How can a Rural Consultant serve the VISN?

VISN 16 serves a great number of veterans who live a significant distance from the network's 10 VA Medical centers. The VISN is home to 1.8 million rural veterans. Of the network's 590,000 enrollees, over half are rural. The long driving distances mean many veterans lack adequate access to care. As of FY 2006, only 27% of veterans living in rural areas and 38% of veterans living in highly rural areas met guidelines for access to primary care, and only 53% of rural and 26% of highly rural veterans met guidelines for access to acute care. Demand for healthcare access is expected to increase, while at the same time, the healthcare provider supply in rural areas is expected to decrease. The numbers show room for improvement, and VISN 16 is dedicated to improving access for rural veterans. My job is to pull together the big picture in terms of serving our rural veterans. I coordinate teams, keeping projects working together efficiently and effectively. I'm charged with putting together an infrastructure and sustainability plan to ensure that improvements we make are sustainable at the local and network levels. The VISN is dedicated to supporting evidence-based care with measurable results, and I will coordinate activities that measure our successes and the needs of our veterans, such as demographics, health outcomes, telehealth participation, and wait times, among others.

In addition to my activities within VISN 16, I'll be leading activities in building a community of practice to facilitate information sharing across VISNs on topics pertinent to rural veterans' health care.

With demand increasing and supply decreasing, how can the VISN address these challenges?

An important part of my role as the Rural Consultant is to enhance our relationships within the community, initiating and strengthening partnerships that can increase access to rural healthcare through education and improved communication systems.

(continued on page 2)

New VISN 16 Rural Health Consultant continued…

I'll be working with such partners as the National Association of Mental Illness (NAMI), community health care providers including Federally Qualified Health Centers (FQHC), local Veterans Service Organizations, Indian Health Services, Rural Access Clinics, and Department of Defense assets such as National Guard Armories to create an inventory of existing medical services and to identify partners to improve access. In addition, the VISN has several ongoing initiatives to support rural veterans, including our expanding telehealth programs, Capital Assets Realignment Enhancement Services (CARES), Seamless Transition for new veterans, and outreach focused on OEF/OIF veterans.

What kinds of telehealth efforts are underway now?

The VISN's Clinical Systems Program Office has designed the Telehealth and Rural Access Program (TRAP), which is dedicated to pursuing increased access to health care using telecommunication technology. TRAP coordinates telehealth activities and rural health initiatives. We have just sent out a call for member recommendations for the Telehealth and Rural Access Advisory Council (TRAAC), a VISN-wide advisory council to guide the activities of the TRAP and maintain continuity.

We've also sent out a request across the network to solicit proposals for rural projects that would be beneficial at the local level. We're also in the process of putting together a virtual rural resource center to support all the rural initiatives. The vision is for it to provide education, facilitate communication among providers, and, we hope, serve as a forum for future collaboration on rural and telehealth research. For example, we want to include something like interactive maps, to provide easy access to information about the CBOCs that we've been gathering in our CBOC needs assessments. The center will work as a one-stop shopping center for rural providers.

What's coming in the near future?

We expect several calls for proposals this year from the Office of Rural Health, and so we're proactively getting people's local proposals and ideas so we can facilitate collaboration in those areas within our VISN.

Our goal is to get the patients the care they need, and we've paired telehealth and rural access because they go in hand so often, but that doesn't exclude other rural efforts that don't include telemedicine. As the VISN's Rural Consultant, I assist individuals and programs throughout the VISN to conduct, coordinate, promote, and disseminate research into issues affecting veterans who live in rural areas, as well as to develop, refine, and promulgate policies, best practices, lessons learned, and innovative and successful programs to improve care and services for veterans living in geographically isolated areas.

RURAL HEALTH RESOURCES UPDATE

DISSEMINATION RURAL HEALTH RESEARCH TO STATE AND NATIONAL AUDIENCES: A COMMUNICATIONS TOOLKIT FOR HEALTH RESEARCHERS

This toolkit is designed to enhance communication and dissemination of rural health services research. It includes approaches for both developing research-related documents and disseminating research results. The toolkit is designed to be a straightforward, easy-to-use reference guide and highlights common methods of packaging and dissemination information that are identified as important to key target audiences (e.g., policy makers, national health related organizations).

The toolkit is based on information from the Rural Health Research Gateway's National and State Audience Needs Study Reports, the RUPRI Health Panel meeting summary, and other resources. In year three of the Rural Health Research Gateway project, research dissemination on a local level will be examined and new findings will be added to the toolkit.

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To view a PDF of the toolkit, please visit: http://www.ruralhealthresearch.org/pdf/toolkit.pdf.

MEET THE MIRECC RESEARCHERS

Tim Kimbrell, M.D.
Staff Physician, CAVHS
Associate Professor of Psychiatry
University of Arkansas for Medical Sciences

What is your area of research?

I am involved in several areas of research, but spend most of my limited research time with posttraumatic stress disorder (PTSD) studies. I spent about eight years seeing exclusively PTSD patients here at CAVHS. This experience was very informative; though somewhat painful as a large percentage of combat-related PTSD patients do not have good response to treatment. I was lucky to work with Tom Freeman during that time. Tom was ahead of the curve in examining factors that contribute to resilience and vulnerability to trauma. We still have data sets to mine that will examine differences in neuropeptide levels and genetic markers in former prisoners of war (POWs) with and without PTSD. Although the MIRECC did not fund this study a couple of years back, we have found funding from outside sources.

Returning veterans from Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) are reporting relatively high rates of mental health disorders and there is increased VA and Department of Defense interest in PTSD research. With this renewed interest I have been fortunate to have been asked to collaborate with Jeff Pyne and John Fortney on their PTSD studies.

I am particularity interested in emotional/affective emotional processing in patients with PTSD and depression. Using an eye-tracker to measure where a subject is directing visual attention, you can objectively determine what type of stimuli a PTSD or depressed patient engages or avoids. We are using this study method in PTSD subjects currently and I would like to expand it to the study of depressed patients in order to predict treatment response.

I also consult on UAMS transcranial magnetic stimulation (TMS) studies.

What active studies do you have going?

I currently collaborate with Jeff Pyne on his two PTSD studies that are examining psychophysiology variables in OEF/OIF veterans and on John Fortney's telemental health PTSD that will be getting started this summer. I will be starting a MIRECC pilot study to examine augmenting PTSD treatment with a hand-held bio-feedback device in rural OEF/OIF PTSD patients. Tom Freeman and I continue to examine the former POW data set mentioned above.

I also collaborate with Mark Mennemier, a psychologist working with the UAMS Neuroscience Institute on his TMS studies. Mark is investigating the effect of low frequency TMS as a possible treatment of tinnitus. I was lucky to be in on the ground floor of TMS as a possible intervention for brain-based disorders. I gave Mark my protocol to facilitate his efforts and provide clinical training to his research staff.

What are the implications or potential benefits of your research?

I hope that we will soon be in the position to augment symptom report with ecologically valid objective measures of psychopathology. I would like to see us be able to: 1) predict with reasonable sensitivity and specificity who is at risk for development of PTSD; 2) predict which depressed or anxious patients will respond to specific treatments.

How did you get started in this area of research?

When I came to work at CAVHS there was an opening in the PTSD section. The affective instability of patients with PTSD is somewhat similar to patients with affective disorders. However, the chief reason is that there was an opening for the job.

(continued on page 4)

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What person or experience had the most influence on your research career?

Bob Post wrote a very influential paper, 'Transduction of psychosocial stress into the neurobiology of recurrent affective disorder'. The paper describes the impact of psychosocial stressors on subsequent psychopathology and hypothesized change in gene expression from environmental influences. The paper was way ahead of its time. I then went to work in his lab for three and a half years. Dr. Post's enthusiasm for learning was infectious and his ability to synthesize information from diverse fields informed his thinking. He collaborates with a wide group of clinicians and basic scientists, anyone who can help answer questions. I go to PubMed each morning and scan each new publication abstract that is found under the headings 'PTSD' or depression'.

The experience of clinically evaluating about 4,000 veterans with PTSD has also been very influential. Clinical research needs be informed by clinical realities. Lack of awareness of the complex clinical realities of PTSD patients has hindered research over the last couple of decades.

What advice would you give to junior investigators and to people who are new to research?

Collaborate with diversity in mind. There will not be a single methodology or single area of investigation that will answer all of your questions. Collaborate with people whose strengths complement your own. In addition, learn to write grants early in your career. As primarily a clinician or a clinician researcher from an intramural program where a good protocol is as good as a successful grant, you will not have experience in successful grant writing. You need to collaborate with those that have these skills.

How can people get in touch with you if they have questions about your work?

Timothy.Kimbrell@va.gov or (501) 257-3460.

KEEPING UP WITH MIRECC RESEARCH

CALM: IMPROVING PRIMARY CARE OUTCOMES

PI: GREER SULLIVAN, MD, MSPH

Coordinated Anxiety Learning and Management (CALM) is an effectiveness study that examines a collaborative approach to treating anxiety within primary care settings by adding a care-manager to the clinic staff. Patients who qualify, and choose to take part in the study, have a choice between two effective treatments for anxiety – cognitive behavioral therapy, medication, or both. This is a multi-site project being conducted in collaboration with the University of California at Los Angeles, University of Washington, RAND, University of California at San Diego, and the University of Arkansas for Medical Sciences. CALM is being tested in a diverse population of adults drawn from west coast and southern rural and urban sites. Approximately 40% of subjects are members of ethnic minority groups. CALM will specifically evaluate the interventions' effectiveness in patients from low socioeconomic and minority backgrounds in keeping with the NIMH priority to develop mental health interventions that work within diverse populations.

Anxiety disorders are highly prevalent, distressing, and disabling. Most patients with anxiety and depressive disorders who do receive mental health treatment receive it in primary care settings, where the quality of mental health care is generally poor. By using a collaborative care approach, CALM draws on the NIMH-supported concept of multi-disciplinary treatment teams. A range of investigations has documented the effectiveness of care-manager assisted chronic disease management programs for depression in primary care settings, using a spectrum of designs, treatment-delivery techniques, and settings. In contrast, anxiety disorders have been largely neglected, despite the fact that they are more prevalent than depression, and equally as disabling and costly, with a consequent higher total burden of illness and public health impact. This neglect is due, in part, to the multiple anxiety disorder diagnoses, which have prevented the kind of uniform and efficient approach required for a public health intervention, in contrast to the more unitary nature of depressive disorders. CALM is designed to show that a relatively uniform, yet flexible service delivery strategy, designed to maximize both patient engagement and treatment efficiency, can be effective both overall, and within specific anxiety disorder diagnoses, including those with co-morbid depression.

THE SOUTH CENTRAL MIRECC CONSUMER ADVISORY BOARD (CAB) VETERAN PROFILE: LAKIESHA MITCHELL

Interviewed By Carrie Edlund, MS

To ensure that the SC MIRECC is responsive to consumers of VA mental health services, and in keeping with the direction of the President's New Freedom Commission recommendations, the SC MIRECC and the VISN 16 Mental Health Product Line established the network Consumer Advisory Board in 2002. The SC MIRECC's Consumer Advisory Board (CAB) includes patients, consumer advocates, administrators, public health experts, and clinicians. These consumers of VA mental health services advise the Mental Health Product Line and the SC MIRECC regarding needed improvements in VA mental health services and review education and clinical services materials developed by the SC MIRECC. This month we profile CAB Coordinator Lakiesha Mitchell.

Who serves on the Consumer Advisory Board?

CAB members include representatives from Veterans Organizations, NAMI (the National Alliance on Mental Illness), Consumers, VISN leaders, VA Medical Center managers, Front Line clinicians, and Public Health leaders.

What do you see as the Consumer Advisory Board's mission?

As a board, our mission is to advise the South Central VA Health Care Network (VISN 16) Mental Illness Research, Education, and Clinical Center (MIRECC) and the Mental Health Product Line (MHPL), regarding the development of educational programs and improvement of clinical services to benefit veterans—and then educate veterans, consumers, and their families about those programs and services.

What is your role on the Consumer Advisory Board?

As the Coordinator for the Consumer Advisory Board, my role entails coordinating and overseeing activities relevant to CAB business, such as:

- Convening and facilitating regular CAB meetings and special events like the Annual Retreat, in collaboration with the Chairman of the CAB, the SC MIRECC Associate Directors for Education and for Improving Clinical Services, and the Mental Health Product Line Manager; and creating agendas and distributing minutes
- Corresponding with the VISN's local Consumer Advisory Councils and distributing information among those groups
- Interviewing veterans and writing feature stories for the SC MIRECC Communiqué newsletter
- Maintaining CAB records, reports, and other vital project information

How did you become involved with the Consumer Advisory Board?

I was initially approached by Dr. Kirchner about the position. I've worked with Dr. Kirchner for many years, assisting her on her alcohol and rural project, and she knew of my experience as a Chaplain's Assistant in the Army National Guard and my degree and interest in journalism. She knew I could relate to the veterans we'd be interacting with on the CAB.

What is a typical CAB meeting like?

Meetings will consist of brief reports from the SC MIRECC and the Mental Health Product Line about current educational activities and programs, clinical services, and research; and discussions of priorities. The CAB will provide feedback and suggest programs or areas of research for further development.

(continued on page 6)

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Most CAB quarterly meetings are held over the telephone, since CAB members come from all across the VISN.

Then we have one annual face-to-face meeting in conjunction with the SC MIRECC retreat in the spring. At the retreat we come up with new goals, which guide our selection of projects and researchers we work with throughout the year. Then the CAB keeps abreast of those projects and the activities of local veterans' advisory councils to let everyone know what's going on in those communities.

What were this year's CAB goals?

(1) form an alliance with community partners; (2) increase awareness by educating at the local, state, and federal levels; and (3) expand the definition of "soldier" to encompass the families, who are also impacted. The CAB realigned its membership infrastructure to include a spouse (male or female) and a child of a veteran to help close the gap in understanding how these families are affected and what they need. In addition, the board felt compelled to include a military service chaplain or representation from a Chaplain's Corps to link the board with churches or religious foundations, which play a great role in the community, particularly the rural community.

What is your favorite thing about your involvement with the CAB?

I'm especially pleased that we're trying to include families and the church as a way to reach out to veterans, especially underserved veterans. CAB is doing what they say they will—you see the researchers, families, church, and community working together to help the veterans. I am passionate about this goal because, during my time in the Army National Guard as a Chaplain's Assistant, I ran into so many soldiers whose families were impacted by the separation of deployment. So often, support for these soldiers slipped through the cracks on the National Guard side, because it wasn't "active duty" and although it wasn't said, time didn't allow for follow-up. So personally, my desire is to reach those National Guardsmen/Airmen and Reservists and their families who still deserve the time and attention that goes into facilitating those mental, physical and emotional issues that have until recent years been overlooked.

The CAB also provides researchers and educators with feedback about their projects, right?

Yes. For example, the CAB reviewed an information wallet card created by the Mental Health QUERI about the anti-psychotic medication clozapine. CAB members can provide important feedback about how such products work for veterans.

What have you learned about mental illness?

Mental illness is an unbiased ailment. It can impact anyone. Working in psychiatry research has opened my eyes to humanity. I have often thought, which is more debilitating--a mental illness or a physical handicap? I believe that the severity of a mental illness can be the most debilitating experience in a person's life. I must say that what I've learned about mental illness is that no one is excused from the effects of mental illness, which is why it is so important that we strive to erase the stigma.

What are you other projects, hobbies, and interests?

My time is split between coordinating the CAB and working as the Project Director for the Evaluation of Life Guard, a Community-based Workshop for Returning Veterans, which is another SC MIRECC-funded initiative. Before I had my five-year-old daughter, Maegan Elise, I had many hobbies and interests (I say this affectionately). Those activities consisted of coordinating weddings and other special events and making gift baskets for special occasions. Actually, that hobby became a side gig that I called MASTERMINDS. However, I haven't been able to get involved in those indulgences for the past few years. So, now, I spend most of my time taking care of my family. It has still been a rewarding payoff; however, I do still enjoy decorating and reading a good book here and there. My latest good read is *The Audacity of Hope*.

RECOVERY CORNER

COMMITMENT AND OVERCOMING RESISTANCE TO CHANGE

Paul Moitoso MSW, LICSW, BCD

LRC/Recovery Services Consultant

Overton Brooks VAMC

Since the founding of our country, the rate of survival for war wounds has significantly increased. Civil War Soldiers had less than a 50% chance of surviving wounds after treatment (Wright, 2008), but by the end of World War II, the survival rate for soldiers had improved to 95.5% (Answers.com, 2009). Thanks in large part to advances in battlefield medicine and technology, 2004 Gulf War soldiers had even a greater survival rate (99.4%) after reaching a field hospital (Wright, 2008). This dramatic improvement in survival rates for injured combat veterans has brought with it a host of new challenges, including a tidal wave of medical and mental health issues. Though the need for care is greater than ever, less than half of U.S. veterans of the Iraq and Afghanistan wars have sought healthcare from the Veterans Administration (VA) (Zoroya, 2008). The numbers are staggering; for example, according to a RAND Corp study (2008), up to 320,000 troops who served in Iraq and Afghanistan have suffered traumatic brain injury. Healthcare professionals must not only assist them, but also provide their families needed help with adapting to the challenges of caring for a wounded veteran.

It is within this context that VA health services are undergoing an unprecedented transformation to improve care and service delivery for soldiers, veterans and their beneficiaries. This monumental task involves reorienting the VA to support a recovery-oriented approach to care with a focus in promoting the values of self-determination, empowering relationships based on trust, understanding and respect, the development of meaningful roles in society, and the elimination of stigma and discrimination (Samhsa, 2009).

Nevertheless, commitment and overcoming resistance to change are at the heart of the VA's transformation to a more recovery-oriented model of care. It is important to remember that change is frequently disruptive and does not occur without some degree of opposition or even conflict. While skepticism to change can be healthy if it sheds light on the weaknesses of a proposed change, moving beyond the barriers of resistance can only occur with an increased awareness of what is fueling such doubt.
Four primary causes of resistance to change are as follows:

(1) Parochial self interest: Individuals are more concerned with the implications for themselves
(2) Misunderstanding: Communications problems and inadequate information
(3) Low tolerance of change: Sense of insecurity and different assessment of the situation
(4) Incongruity about the need for change: Disagreement over the advantages and disadvantages
(Tutor2you, 2009)

When an organization proactively invests significant time and attention to identify what resistance might develop, the challenge of overcoming those barriers gives way to opportunities for success. Leadership can seize these unique opportunities by inspiring and reinvigorating staff working on the frontline of transformational efforts. Clear guidance and objectives, mission-focused training, and sufficient personnel are needed to accomplish this task. Through their unwavering commitment, leadership can foster local support, prevent the fragmentation of duties and the loss of talented personnel secondary to disillusionment and burnout.

An effective tactical approach that leadership can employ is the creation of a realistic and detailed plan that addresses the potential roadblocks that could prevent successful transformation.

(continued on page 8)

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It is not enough to merely agree that a transformation is needed; leadership must get down into the trenches to survey the conditions and provide the frontline with the tools, personnel, support and training needed to be successful.

It is imperative to involve stakeholders in the development of such tactical plans. Their involvement in helping to define the problems at hand will help lead to an acceptable solution being developed and needed changes implemented. More specifically, an effective change management plan includes the following steps:

a. Deciding on the main goal
b. Choosing a mechanism of involvement to achieve that goal
c. Identifying potential barriers and solutions
d. Monitoring the process of involvement
e. Evaluating outcomes of the project (i.e., measuring if goal has been met)
f. Using data collected to inform methodology of this and future projects.

(Simpson & House, 2003)

It is essential for a change management plan to also promote the positive benefits for the organization and the individual. Such benefits might include opportunities for personal change and development, the novelty of new challenges, a greater sense of ownership, and reduction in boredom. The greater the buy-in by all involved, the better the potential of change being successful, positive and lasting.(Tutor2you, 2009).

One example of utilizing stakeholders successfully to aid in changing the perception of mental health illness within the VA is the implementation of a Veterans Advocacy Council at each facility. These councils are intended to provide a forum for veterans input to be heard and VA leadership to respond about the types and quality of mental health and substance abuse services being offered. Veterans are directly involved in the creation of the council, as well as the identification and problem-solving methods to overcome existing barriers and improve care and service delivery.

In a recent discussion with Mr. George, a Vietnam Veteran who serves as a Veteran Council member, he conveyed, “Veterans with mental health issues need to be actively involved in their care and developing new programs." He shared that, “Without the opportunity to prove that we are able to provide realistic inputs ourselves, how are we ever going to overcome the stigma associated with having a mental health diagnosis?"

The creation of a Veterans Advocacy Council is a change that is proving to be successful because each council has specific goals and a mechanism of direct veteran involvement to achieve these goals. The establishment of these councils is on-going and the outcome is being continually monitored on a national level.

Another example of joint efforts to respond to the VA’s mandate to improve care and service delivery with regards to medical and mental health issues was the creation of the Local Recovery Coordinator (LRC) position within each VA Healthcare System. Within VISN 16, the LRCs joined forces and took on the challenge as a team. The LRCs organized their priorities, shared ideas, and supported each other as obstacles were encountered. Understanding the roots of resistance to change, the LRCs created ways to improve communication, increase tolerance through education and vision sharing, as well as fostered a common vision regarding the need for change. They quickly consolidated their efforts to build a change management plan that involved the aforementioned steps and included stakeholders from veterans to administration. The activities of the LRC are coordinated on the local, regional and national levels in an attempt to ensure continuity across facilities. Two examples of change currently being addressed by the LRCs is the integration of recovery services across all mental health programs and the establishment of activities to eliminate stigma associated with mental illness.

Many accomplishments have been made in the past year. Most facilities within our network have active Mental Health consumer councils. Coordinated trainings and workshops have been provided to mental health staff and community partners. Additionally, therapy and educational groups have been initiated, as have been the training of clinicians in recovery-oriented practice.

By embracing the changes necessary to overcome the modern challenges of caring for our veterans, we have the potential to actively transform our organization for the better.

(continued on page 9)

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Please join the VISN 16 LRCs in a spirit of collaboration, creativity, and a clear purpose. It is with your help that we will be able to continue to fulfill President Lincoln's promise – "To care for him who shall have borne the battle, and for his widow, and his orphan" (VHA, 2009).

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FEBRUARY CONFERENCE CALLS

CALL-IN NUMBER: 1-800-767-1750

		ACCESS CODE
10	MIRECC Leadership Council, 3:30 PM CT	19356#
17	VISN 16 Mental Disaster Team, 11AM CT	76670#
18	MIRECC Program Assistants, 2PM Central	43593#
23	MIRECC Education Core, 3:00 PM CT	16821#
24	MIRECC Leadership Council, 3:30 PM CT	19356#
26	National MIRECC & COE Education Implementation Science Group, 1:00 PM CT	28791#